SENIOR HEALTH NEWS

A publication of the Pennsylvania Health Law Project

Volume 13, Issue 5

October 2011

Part D Plan Options for 2012

The Medicare Annual Enrollment Period (also called Open Enrollment Period) is underway. All Medicare beneficiaries should review their current plan (if they have one) to see if it will continue to meet their needs next year. Factors to consider in this review are:

- **Cost:** Is the premium increasing? If so, is it affordable? How is the cost-sharing changing; specifically, how much is the deductible? What are the co-pays for medications or for other health services needed?
- **Coverage:** Are all the person's prescription drugs going to be covered next year? Are the person's doctors going to be in the plan's network (if looking at a Medicare Advantage Plan)? Will their pharmacy still be in the network?

Individuals who wish to change their Medicare plan (whether it's a stand-alone drug plan or Medicare Advantage Plan) must enroll in the new plan by **December 7th**. This is the last day of the Annual Enrollment Period. Please note that the AEP is earlier this year (running from October 15th through December 7th). Any changes made during this period will be effective January 1, 2012. Individuals who miss this deadline to change plans will only be allowed to change plans for 2012 if they qualify for a Special Enrollment Period (i.e., if they are a dual eligible, have a low-income subsidy, or lose creditable coverage).

Stand-alone Drug Plans

In 2012, Pennsylvania has 36 stand-alone drug plans available to people across the state (individuals who get their Medicare through Original Medicare join a stand-alone drug plan for their drug coverage). Twelve of these plans are zero-premium for dual eligibles and other individuals with the full low-income subsidy. Please see PHLP's website (www.phlp.org) for a list of 2012 zero-premium plans.

Medicare Advantage Plans

Every county has many Medicare Advantage Plan options in 2012. Medicare Advantage Plans are managed care plans that provide

(Continued on Page 2)

INSIDE THIS EDITION

(Continued from Page 1)

individuals with all their Medicare Part A and Part B coverage; many Medicare Advantage plans also include prescription drug coverage (Part D) as part of their covered benefits. Beneficiaries in Bradford and Warren Counties have the fewest Medicare Advantage plan choices in 2012 (16 plans), while those living in Berks County have the most options (45 plans). Most counties have between 20-40 plans available to people on Medicare in 2012.

Special Needs Plans

Special Needs Plans (SNPs) are types of Medicare Advantage plans that limit their enrollment to certain groups of Medicare beneficiaries. Currently, PA has the following types of Special Needs Plans:

- D-SNPs: These plans are limited to people who are full benefit dual eligibles-people with Medicare and full Medicaid coverage.
- C-SNPs: These plans are limited to people with certain chronic conditions determined by the plan. PA has C-SNPs for people with diabetes mellitus and C-SNPs for people with chronic heart failure and diabetes.
- I-SNPs: These plans are for people who reside in a long-term care facility such as a nursing home and/or for people who need long-term care services but who are living in the community (such as recipients of the Aging Waiver).

The number and type of SNPs available differs by county. All but 8 counties (Bradford, Centre, Fulton, Franklin, Pike, Potter, Tioga, and Wayne) have at least one D-SNP available for people with both Medicare and Medicaid in 2012. UPMC Health Plan is offering a new D-SNP called UPMC for You Advantage in many of the counties where they also offer the UPMC for Life Specialty Plan; these counties are primarily in the western half of the state. Gateway Medicare Assured, another D-SNP, is expanding beyond Western and Central PA and will be available to dual eligibles in Philadelphia County in 2012.

Information about all the 2012 Prescription Drug Plans (PDPs) and Medicare Advantage Plans (including Special Needs Plans) is now available on www.medicare.gov and in the *Medicare & You 2012* Handbook sent to all Medicare beneficiaries. Individuals who need assistance with 2012 plan choices should call APPRISE at 1-800-783-7067 or Medicare at 1-800-633-4227.

PA Scores Low on Long-Term Services and Supports Scorecard

AARP, The Commonwealth Fund and the SCAN Foundation created a scorecard of states that measured Long-Term Care Services and Supports provided to older adults and people with disabilities. The scores were based on the following aspects of the states' provision of long-term care: affordability and access, choice of setting and provider, quality of life and quality of care, and support for family caregivers. PA overall ranked 39th of 50 States and the District of Columbia. Despite the overall low score, PA was in the top quartile of states in the area of choice of setting and provider and was ranked number one in the area of facilitating consumer choice.

The report can be viewed online at: http://assets.aarp.org/rgcenter/ppi/ltc/ltss_scorecard.pdf.

No Medicare Part D Co-Pays for Waiver Recipients Starting in 2012!

Just like dual eligible consumers who receive long term care services in nursing homes, Medicare consumers who receive their long-term care services through one of Pennsylvania's home and community-based waiver programs will soon have no co-pays for their Medicare Part D prescription medications.

This change goes into effect January 1, 2012, and applies to all Medicare beneficiaries who are also enrolled in one of these waiver programs:

- Aging (PDA) Waiver
- LIFE Program
- Attendant Care Waiver
- Independence Waiver
- COMMCARE Waiver
- OBRA Waiver
- Person/Family Directed Support (PFDS) Waiver
- Consolidated Waiver
- AIDS Waiver
- Adult Autism Waiver

Currently, these beneficiaries are considered "full dual eligibles" which means they are automatically entitled to a full Low Income Subsidy (LIS) from Medicare and they pay small co-pays for their Part D covered drugs ($1.10 or $2.50 for generics; $3.30 or $6.30 for name brands, depending on their income). **Beginning in 2012, however, they should be able to get their Part D drugs at no cost.**

Once Medicare receives information from a state that a Medicare beneficiary is also in a waiver program, it will inform the beneficiary's Part D Plan that the person should be charged no co-pays for medications covered by the Plan. The Plan then changes their system so that when a pharmacy bills the Plan for a medication, it goes through without any co-pay being charged to the consumer.

If the consumer is not already in a Part D Plan, Medicare will auto-enroll the person into a zero-premium PDP and inform the Plan that the consumer should be charged no co-pays.

PHLP and other Medicare advocates are concerned that consumers covered by this policy may still find themselves being charged co-pays by their Plan after January 1st. If that is the case, the consumer (or someone acting on their behalf) should give the Part D Plan proof that he is enrolled in a waiver program (i.e., a copy of their eligibility notice or a copy of the waiver service plan). The Plan must accept the proof and stop charging co-pays.

More information about this change can be found on PHLP's website in a Fact Sheet entitled *No Medicare Part D Co-Pays for Waiver Recipients in 2012.*

For help with waiver participants being incorrectly charged Part D co-pays in 2012, call PHLP's Helpline at 1-800-274-3258.

Medicare Part A and B Costs for 2012 Announced

The Centers for Medicare & Medicaid Services (CMS) announced changes to Medicare premiums, deductibles and co-pays that will take effect January 1, 2011. Part B costs are actually decreasing next year, which is good news for beneficiaries.

Medicare Part A

Part A is the hospital benefit of Medicare that covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services (care for the terminally ill). In 2012, the Part A hospital deductible will be $1,156 (up from $1,132 in 2011). If someone is in the hospital longer than 60 days, their cost-sharing in 2012 will be:

- $289/day for days 61-90 (up from $283 in 2011)
- $578/day for days 90-150 (up from $566 in 2011)

Medicare beneficiaries in a skilled nursing facility that accepts Medicare will pay $144.50/day for days 21-100 (compared to $141.50 in 2011). There is no cost for skilled nursing facility care for the first 20 days of Medicare coverage.

Medicare Part B

Part B is the medical benefit of Medicare that covers outpatient services such as doctor visits, outpatient surgery, diagnostic tests, ambulance services, durable medical equipment, and therapy for mental health conditions. The Part B premium in 2012 will be $99.90/month. Right now, Medicare beneficiaries are paying different premium amounts depending on when they became eligible for Medicare. Next year, all Medicare beneficiaries will pay the same premium-$99.90/month.

As in previous years, beneficiaries with higher income (i.e., a modified adjusted gross annual income greater than $85,000 for a single person/$170,000 for a married couple) will pay a higher Part B monthly premium on a sliding scale, depending on their income.

The Part B annual deductible will be $140 in 2012 (down from $162 in 2011). Once the deductible is met, Medicare covers physical health services at 80%. Most mental health services will be covered at 60% in 2012. Currently, Medicare covers mental health services at 55%. By 2014, Medicare will cover mental health services at 80% so there will no longer be a difference between what Medicare pays for physical and mental health services.

Medicare Part D Costs in 2012

Part D costs differ from Plan to Plan. The 2012 monthly premium for stand-alone Part D Plans in PA ranges from $15.10 to $115.60 per month. The "benchmark premium" for Part D plans in Pennsylvania next year is $34.32. This is the maximum amount the Low-Income Subsidy (explained below) will pay toward a premium for someone awarded a full subsidy who is in a standard Part D plan.

In addition to their Plan's premium, consumers who do not qualify for a subsidy will pay the following for a 2012 Standard Part D Plan:

- An annual deductible of **$320** (up from $310 in 2011)
- During their initial coverage period the consumer pays a 25% co-pay for each prescription until their total drug costs reach **$2,930** (up from $2,840 in 2011)
- During their coverage gap (also referred to as the "doughnut hole"), the consumer will pay a percentage of the costs of their drugs (in 2012 the consumer will get a 50% discount on brand-name drugs and a 14% discount on generics) until their total out-of-pocket expenses reach **$4,700** (this figure was $4,550 for 2011) and
- During the catastrophic coverage period a consumer will pay a co-pay of **$2.60** for generics and **$6.50** for name-brand drugs, or a 5% co-pay, *whichever is greater* (the current co-pays are $2.50 and $6.30)

More information about the costs of Medicare Part D coverage in 2012 can be found by contacting 1-800-MEDICARE (1-800-633-4227) or looking on www.medicare.gov.

LIS Costs in 2012

The Low-Income Subsidy (LIS) program helps qualified consumers with the costs of Medicare Part D. In 2012, people eligible for the full subsidy will pay only these small co-pays for their medications (depending on their income):

- $1.10 generics/$3.30 brand name (unchanged from 2011)
- $2.60 generics/$6.50 brand name drugs (up slightly from $2.50 generics/$6.30 brand name this year)

For individuals who qualify for a partial subsidy, the annual deductible is reduced to $65. Once the deductible is met, these individuals pay 15% of their drug costs until they reach $4,700 in out-of-pocket spending. At that point, they pay $2.60 for generics and $6.50 for brand name drugs for the rest of the year.

There is no coverage gap or "doughnut hole" for people who receive any subsidy.

Please support PHLP by making a donation through the United Way of Southeastern PA. Go to www.uwsepa.org and select Donor Choice number 10277.

PA Submits Letter of Intent to Implement a Demonstration Project to Integrate Care for Dual Eligibles

The federal government has money available for states to test models of integrated care for dual eligible consumers (those on Medicare and Medicaid). DPW has decided to pursue this funding and recently sent a "Letter of Intent" to the Centers for Medicare and Medicaid Services (CMS) with a request to begin discussions on a project piloting integrated care in Pennsylvania. If DPW receives the funding, the state will develop one or more models that will integrate all care (physical health, behavioral health and long-term care services) and test them over a three year period beginning at the end of 2012.

The Department committed to keeping stakeholders informed throughout the planning and pilot process. This month, they solicited input from stakeholders regarding recommendations for models the Department may consider. PHLP, on behalf of the Consumer Subcommittee of the Medical Assistance Advisory Committee, submitted comments expressing support for the state's consideration of models beyond a capitated one through managed care. In addition, the Consumers emphasized the importance of consumer choice in terms of joining any demonstration and opposed any passive enrollment into demonstration model(s). The Consumers also recommended: meaningful consumer participation in all stages of development and implementation of integrated care models; consumer-centered standards (including a consumer's right to self-direct any long-term care support services) in any models developed; comprehensive provider networks spanning the entire spectrum of physical health, behavioral health and long-term care services; a transition period allowing consumers to continue accessing providers and services to ensure continuity of care at the beginning of the integration pilot; and clear information and notices to consumers about enrollment rights and options, program benefits and rules.

Readers may recall that in past years, the Commonwealth had extensively explored integrating care through the Medicare Advantage Special Needs Plans. These plans were to also provide Medicaid physical health and long-term supports and services, in addition to the Medicare services. However, implementation was delayed for logistical reasons and after substantial criticism from dual eligible consumers and their advocates. We will report on the state's planning and activities in this area in upcoming newsletters.

Update on Medicare's Marketing Rules: What Is and Isn't Allowed

During the Medicare Annual Enrollment Period (October 15th-December 7th), Medicare beneficiaries are talking with Medicare Plan agents and brokers who sell Medicare plans about 2012 Plan options. Unfortunately, during this period insurance agents and brokers sometimes engage in prohibited behavior in order to sell someone a Medicare policy. Medicare has marketing rules that **all** Medicare Advantage and Medicare Prescription Drug plan (PDP) agents and brokers must follow. Any agent or broker selling a Medicare Advantage Plan or PDP must be state-licensed, certified or registered. In addition, they must be trained/tested annually about Medicare rules and regulations, and on the details of the plans they are selling.

(Continued on Page 7)

(Continued from Page 6)

Here are highlights of what is allowed, and what is not allowed, when marketing Medicare Advantage Plans and PDPs.

Agents/Brokers are allowed to:

- Call a Medicare beneficiary who has given permission to be called.
- Call or visit a Medicare beneficiary who attended a sales event if the person gave permission for this.
- Conduct sales activities in common areas of healthcare settings (i.e., hospital or nursing home cafeterias, community or recreational rooms, conference rooms).
- Offer gifts to potential enrollees (valued at no more than $15) as long as the gift is provided to consumers whether or not they enroll in the plan.

Agents/Brokers are not allowed to:

- Say they are from Medicare or use “Medicare” in a misleading manner.
- Solicit potential enrollees door-to-door.
- Make outbound marketing calls.
- Approach Medicare beneficiaries in public places (such as parking lots, hallways, lobbies or sidewalks).
- Conduct sales activities in health care settings except in common areas as described above; marketing is not allowed in waiting rooms, exam rooms and hospital patient rooms, dialysis centers, or pharmacy counter areas.
- Provide meals to potential enrollees at sales presentations.
- Conduct marketing or sales activities at an educational event (such as health information fairs or state or community-sponsored events).
- Cross sell products during any Medicare Advantage or Part D sales activity/presentation. That means the agent cannot try to sell any other products such as annuities, life insurance or Medigaps at the same time. Additional insurance products can only be discussed if a beneficiary requests information about the product and this discussion occurs during a separate appointment.

Please note that if an agent or broker has an appointment with a Medicare beneficiary to discuss a Medicare Advantage or Prescription Drug Plan, the agent/broker must specify, *before this meeting*, which type of product will be discussed during that meeting, the beneficiary must agree to this, and the agreement must be documented or recorded.

Individuals who have an experience with an agent/broker who engaged in prohibited practices or behavior should try to get the name of the agent/broker and report that person to Medicare (1-800-633-4227). Concerns or specific complaints can also be reported to APPRISE at 1-800-783-7067.

We Need Your Help! Support PHLP

PHLP offers its services free of charge and relies on contributions like yours.

Thousands of people rely on PHLP every year to guide them through the processes of identifying coverage, appealing denials, filing grievances, and preparing for hearings. We help consumers and their advocates make sense of public health insurance, including eligibility, coverage, and consumer rights. In addition, we work with other organizations and government agencies to improve Pennsylvania's health care system through a variety of advocacy and policy avenues.

Please consider making a donation through the enclosed donation envelope or using our secure online form at www.phlp.org.

Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St., Suite 400
Philadelphia, PA 19106